Mount Sinai

MEDICAL CENTER

June 17, 2019

Linda D. Smith Associate Regional Administrator Division of Survey & Certification Department of Health & Human Services Centers for Medicare & Medicaid Services 61 Forsyth Street SW, Suite 4T20 Atlanta, Georgia 30303-8909

RE: CMS Certification Number (CCN) 10-0034

Dear Ms. Smith.

We are in receipt of your correspondence dated June 10, 2019 outlining the results of the survey that was conducted at Mount Sinai Medical Center on June 4, 2019.

Enclosed you will find the Action Plan we have developed in order to correct the deficiencies found in the COPs for 42 CFR 482.12 Governing Body, 42 CFR 482.13 Patient Rights, and 42 CFR 482.21 QAPI.

We look forward to receiving your approval of this Action Plan. If you have any questions or require any further information please contact Cathy McClellan at 305-674-2555.

Thank you for your consideration in this matter.

Sincerely,

Steven D. Sonenreich

President and Chief Executive Officer

Mount Sinai Medical Center

cc:

Arlene Mayo-Davis Field Office Manager

8333 NW 53rd St. Suite 200

Miami, Florida 33166

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 100034 B. WING 06/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MOUNT SINAI MEDICAL CENTER MIAMI BEACH, FL 33140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) A-043 CFR(s): 482.12 A 000 **INITIAL COMMENTS** The Professional Affairs Committee (PAC) of the A 000 Board of Trustees of the Medical Center will provide oversight and accountability to ensure that patient An unannounced federal complaint survey, rights are protected, a safe environment is maintained, clear expectations for patient safety are complaint number: 2019008293, was conducted set and an effective Quality and Performance on 05/29/2019 to 05/30/2019 and 06/04/2019 at Improvement program is in place. The PAC is Mount Sinai Medical Center, which is located at compromised of several members of the Governing 4300 Alton Road, Miami, FL. 33140 to review the Board, Hospital CEO, Chief of Staff, Medical Staff Conditions of Participation: Patient Rights. Leadership, Chief Nursing Officer, Chief Medical Office, Senior Vice President of Special Services, Governing Body and Quality Assessment and Vice President of Quality. The PAC meets Performance Improvement (QAPI). monthly and reports its activities to the full Hospital Governing Board. The plan for improving the Mount Sinai Medical Center was not in processes that lead to the deficiencies cited includes compliance with the Federal Regulations at 42 how the hospital is addressing improvements in its CFR 482 requirements for Acute Care Hospitals. systems, in order to prevent the likelihood of recurrence of the deficient practice. It was identified that the hospital had multiple conflicting policies that Immediate Jeopardy was identified on 05/29/2019 required review, feedback and updates. The and ongoing at the Condition of Participation: following policies will be reviewed by PAC on the Patient Rights A-115. next scheduled meeting (6/18/19) as part of the Condition level deficiencies were identified at: overall action plan presented by the VP of Risk QAPI A-263, and Governing Body A-43. Management: Abuse, Neglect or Exploitation Policy 6/17/19 renamed to Required Reporting of Allegations/ A 043 **GOVERNING BODY** A 043 Possible Abuse, Neglect or Abandonment of CFR(s): 482.12 Patients. This Hospital wide policy defines the steps taken to report abuse, neglect or abandonment There must be an effective governing body that is attributed to either internal or external events. There legally responsible for the conduct of the hospital. is now clear expectation that the appropriate reporting bodies will be contacted, such as DCF if If a hospital does not have an organized abuse is suspected or has occurred. If the allegation governing body, the persons legally responsible involves a hospital employee and a patient, the for the conduct of the hospital must carry out the involved employee will be removed from all patient functions specified in this part that pertain to the contact until the investigation is conducted. The Sexual Assault Protocol (RAPE) – policy has been expanded to a Hospital Wide Policy and now reflects governing body ... a section on how to care for a patient after an alleged This CONDITION is not met as evidenced by: sexual assault, which includes but is not limited to, Based on record reviews, staff interviews, and the Nursing Supervisor or Charge Nurse assigning a review of policies, the governing body failed to 1:1 Patient Safety Tech or Sitter to the patient. The maintain responsibility for the conduct of the Patient Safety Tech or Sitter assigned to the patient will be the gender of the patients choice. The hospital employees and ensure the effectiveness accused employee will be immediately removed from of the person(s) responsible for the conduct of the area of the allegation and will not be able to the hospital employees resulting in an incident of return to work until cleared pending Human sexual assault involving one patient (SP #1) of 4 Resources determination.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

VP. Rish Manusement ? PI

6-17-19

PRINTED: 06/10/2019

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/10/2019 **FORM APPROVED** OMB NO. 0938-0391

ND PLAN OF	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 100034 B. WING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF P	ROVIDER OR SUPPLIER	100034	The state of the s	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	04/2019
	INAI MEDICAL CENTE	ER		4300 ALTON RD MIAMI BEACH, FL 33140		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
A 043 A 057	Continued From pa sampled patients (\$ CHIEF EXECUTIVI	SP). (Refer to A-0057)	A 043	During Shift Hand-Off, staff will com wishes of the patient should they re-	quest	
	CFR(s): 482.12(b)			minimal or no exposure to a particul while under 1:1. Behavioral Health (Safety Policy was revised to further	General	6/13/19
	The governing body must appoint a chief executive officer who is responsible for managing the hospital.			expectations of staff when not in dir- care. The Policy stresses the impor- intervening if they witness actions the	ect patient tance of at did not	
	Based on record in review of policies the	s not met as evidenced by: review, staff interviews and ne governing body failed to		follow policy and the consequences with not following the policy. The All Sexual Misconduct and Police Inves Human Resource Policy was create	egations of stigations – d to provide	6/17/19
	effectiveness of per	naintain responsibility for ensure the ffectiveness of person(s) responsible for the ponduct of the hospital employees resulting in an		an internal procedure for reporting of sexual misconduct perpetuated bemployee and the process that will to	y an	
	incident of sexual a (SP #1) of 4 sample	ssault involving one patient		regarding the subject of such allega conclusion of the investigation, Risk Management and Human Resource	tions. At the	
	Findings include:		the results with the Senior VP/VP of department and the CNO or CMO (a appropriate) and a decision will be n	the affected		
	revealed she arrive	iew of sample patient (SP) #1, d in the ER (Emergency 19 at 10:22 PM. She was		regarding whether to reinstate the eland/or take disciplinary action. A final	mployee al report of	
	Baker Acted on 11/6	06/2018 at 12:01PM for pressive disorder/suicidal		the investigation results and the acti will be reported to the CEO. If an en reinstated prior to completion of a po	ployee is	
		admitted to the Behavioral 6/2018 at 11:00 AM.		investigation, the report shall docum justification for such reinstatement a determined by Human Resources.	ent the	
	Primary Nurse/Staff	ral Health Nursing Notes of the f-D, documented on 2 PM that at 7:40 PM patient		Mandatory comprehensive Sexual Abuse Education was completed by clinical staff which clarified the process regarding allegations.		6/17/19
	approaches register that she has been s	red nurse on duty to complain sexually harassed by sental health technician in her		There were no exceptions for compl for staff that were on a leave of abse- staff member was not scheduled to	etion except ence. If the work, they	
	room 474. Charge r psychiatrist made a Evidence collected			could not return until completion of the education. Nursing Administration held a hudd with Nursing Leaders to explain the process or reporting and what their role is when an		6/14/19
		amed] Hospital for evaluation		allegation is brought to their attention	n.	
RM CMS-256	7(02-99) Previous Versions O	M. Maril		Licility ID: HL100034 If a	continuation shee	et Page 2 o

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		D. 0938-0391
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		100034	B. WNG		O CANADA	С
NAME OF P	ROVIDER OR SUPPLIER	4		STREET ADDRESS, CITY, STATE, ZIP CODE	06/	04/2019
2.2.4.00				1300 ALTON RD		
MOUNTS	INAI MEDICAL CENT	ER				
0/0 ID	CUMMADA	(OTATELIER OF DEFINE		MIAMI BEACH, FL 33140		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO		(X5)
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR		COMPLETION DATE
				DEFICIENCY)		
77.0000000000				Continue from page 2		
A 057	Continued From pa	age 2	A 057	Quality Monitoring and accountabilit CFR(s): 482.12	y for A-043	
	as recommended l	by law enforcement.		Policies listed above were approved	by PAC	
				uploaded to Policy Stat, rolled out to sta	aff and changes	
		Vice President Risk		were communicated via Policy Memo fr	om the Chief	
	Management on 0	5/29/2019 at 11:07AM revealed		Compliance Officer. 2.) A Risk Manage created to validate compliance of daily	ment log was	
	on 11/05/2018, pat	tient complained of being		Director of RM will monitor Nursing Sup	eporung.	
	sexually assaulted	by a Mental Health Technician		in order to complete the log on a daily b	asis. The log	
	(MHT) and identifie	ed employee by name. The		will include verification of the following:	notification of	
	police were called	and conducted an		the CEO by the VP of RM, notifying DC Police and documentation of DCF notification of	F, notifying the	
	investigation. Arrar	ngements were made to		medical record. 3.) BH monitoring log to	cation in the	
	transfer patient wit	h 2-MHT employees to the		checks. This monitoring will be accomp	lished by doing	
	naint the nalise int	enter to be evaluated. At some	Maria Cara	unannounced spot-check visual rounding and by monitoring the camera surveillance in the nursing station real-time. This will be done by Director of BH		
	obtained DNA ener	terviewed the employee and				
	was conducted by	cimen from him. Investigation Risk Management, Human		4.) VP of RM will present Lessons Learn	nector of BH.	
	Resources and the	Behavioral Health Nursing		a result of the RCA. In addition, results	of Quality	
		spoke with employee.		Monitoring will be presented on a month	nly basis until	L are in
		d that he was in the room only		completion of the action plan. 5.) Educa compliance of the BH General Safety P	tion	
		dnesday, 05/22/2019, the		100% as exhibited through the sign-in s	blicy will be	
		tion was informed that the		6/17/19. Evidence of compliance will be	submitted to	
	DNA sample taken	from the patient matched the		the PI department by June 17, 2019. A	weekly report	
	DNA taken from the	e employee and the employee		will be submitted to the PI department to	show	
	was arrested. The	following day, Thursday,		evidence of completion for those employ not scheduled during the roll out of this	education This	
	05/23/2019, the Vid	ce President Risk Management		was rolled out by the Director of BH. 6.)	Education	
		sk Management notified the		compliance of the Sexual Abuse educat	ion will be 90%	
		out did not notify the		compliance as exhibited by the NetLean report by 6/17/19. Of those employees	ning electronic	
	Department of Chil	dren's and Families. The DNA		during the roll-out of this education, all e	not scheduled	
	findings were consi	stent with the police report, on		complete the course before resuming pa	atient care.	
	the breast and the	in the vagina. The actual		This is done by the Manager of Training	and	
	results were not pro	ovided to the facility.		Development. Evidence of compliance submitted to the PI department by 6/17/	will be	
	Interview with Clinic	and Director D. L. C. Liller		report will be submitted to the PI departr	nent to show	
	on 05/20/2010 ct 2	cal Director Behavioral Health		evidence of completion for those employ	ees who were	2 4 10
		:02PM revealed the employee		not scheduled during the roll out of this	education, 7.)	
		1-day training on 05/22/2019 station. This was the last day		Compliance of the New Employee educing	ation will be	
	of work for the emp	loyee. The Clinical Director		documented by the Manager of Training Development. 100% compliance will be	and exhibited by	
	Behavioral Health	nad a staff meeting on		signed check lists submitted to the Quality Manager.		
	11/15/2018 to diece	uss mandatory education on		Purposeful Rounding education will be	e documented	
	abuse and neglect	and remind staff about not		by the Director of Behavioral Health. 100	0% compliance	
	and and thousand	and remind stair about Hot		will be exhibited by sign-in sheet provide	g to the PI	

Previous Versions Obsolete Event ID: BILS11 Facility ID: HL100034 FORM CMS-2567(02-99) Previous Versions Obsolete

entering patient rooms alone. Review of

will be exhibited by sign-in sheet provided to the PI Department.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED C 06/04/2019	
		100034	B. WING				
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1300 ALTON RD WIAMI BEACH, FL 33140		104/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
A 057	Behavioral Health Godocumented on 11/1 Findings/Conclusionalone when doing roduties/tasks. Do not in room, this is regarbest way to protect ypossible physical vio Recommendations/Aor 1:1 support should dining rooms (anywhactivity, get second sondered by the support of Psychologian sheet revealed signatures out of applin attendance. No point signatures of the support of the suppo	eneral Staff Meeting Agenda 5/2018 revealed s: Only enter patient room unds or quickly completing have 1:1 conversations alone dless of gender. This is the courself from allegations and lence. action: Longer conversations d be given in hallway or lere on camera). Any longer staff. No students or th staff to be left alone with them to rooms. Review of hiatry/Behavioral Health	A 057	reporting process outlined in policy of sexual misconduct. This audit wappropriate 1:1 observation was a accused employee was suspende was called and the Police were no of data will be submitted to the Qu show evidence of 100% compliance. A-057 CFR(s) 482.12(b) The Chief Executive Officer appoint Governing Body is responsible for effectiveness of person(s) respons of hospital employees. The CEO pand accountability to ensure that protected, a safe environment is mexpectations for patient safety and Quality and Performance Improver place. The CEO has been in const on all aspects of the action taken to correct the deficiencies and has a paction plans for improving the procethe deficiencies cited. The CEO with the deficiencies cited. The CEO w	y for all allegations will assure that the issigned, that the issigned, that the issigned, that the iddremoved, DCF otified. Four months itality Manager to ce. Inted by the ensuring the sible for the conduct provides oversight patient rights are maintained, set clear an effective ment program is in tant communication to immediately opproved all of the pesses that lead to ill ensure the	6/17/19	
A 115	on 06/04/2019 at 11: has not been present report is in draft to be meeting. PATIENT RIGHTS CFR(s): 482.13 A hospital must prote patient's rights. This CONDITION is Based on record review of policies, the care in a safe setting, right to be free from a 1 (SP #1) out of 4 sar	al Director Behavioral Health 03AM revealed the incident ted to the Board but the expresented at the next expresented at the next extended by: and promote each extended by: and extended by:	A 115	Polices reviewed by PAC will be in Allegations of Sexual Misconduct a Investigations policy now states that the investigation results and the acreported to the CEO by the VP of I I An email sent to clinical staff stress importance of timely completion of comprehensive Sexual Abuse Eduout by the CEO. All clinical staff are complete the training, with no exceemployees were on a leave of absonot complete the education could reare until they have completed the Quality Monitoring and Accounts CFR(s) 482.12 (b): 1.) Policies lists approved by PAC, uploaded to Pol to staff and changes were communified the Compliance of the RCA. In addition, results of Cas outlined in this plan will be presental completion of the action	and Police at a final report of ctions taken will be Risk Management. Sing the the mandatory cation was sent the expected to t	6/13/19	

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Coethy J. McCellar VP, Rish Mgmt; PI

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second second	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED	
		100034	B. WING			C (04/2040	
	ROVIDER OR SUPPLIER INAI MEDICAL CENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 ALTON RD MAMI BEACH, FL 33140	1 06/	04/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
A 115	A 115 Continued From page 4 employee sexually assaulting a patient. The hospital's failure to ensure patients are free from abuse, sexual assault by employees providing care and services resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result		A 115	The Behavioral Health General Safety P revised to be more specific regarding protentering patient rooms. Staff was educated revised policy. The education and training the importance of intervening if they with by other staff that did not follow policy. The and training also included the consequence.	otocols for ed on the g stressed ess actions he education nces	6/13/19	
A 144	patients and requires on the part of the hos A-0145)	m, impairment, or death to simmediate corrective action spital. (Refer to A-0144 and		associated with not following the policy. Resources has developed a policy to de process for employees who are under in law enforcement. Employees under policinvestigation will be reviewed by the Sen President, CNO, CMO (as appropriate) a	ineate the vestigation by e vice Line Vice	6/17/19	
	CFR(s): 482.13(c)(2) The patient has the resetting. This STANDARD is Based on record reversive of policies, the care in a safe setting sample patients (SP) ensure the employee a safe setting resulte jeopardy beginning ocreating a situation the	ight to receive care in a safe not met as evidenced by: riew, staff interviews, and e facility failed to provide , in 1 (SP #1) out of 4 . The hospital's failure to e provide care and services in d in a findings of immediate n 05/29/2019 and ongoing, nat is likely to result in	A 144	of Human Resources to make a joint decappropriateness of the employee returning final report of the actions taken will be received by the VP of Risk Management. In Sexual Abuse Education as described in has been added to New Employee Orientorientation checklist for New Employee Owas revised to validate that staff underst definition of abuse, duty to report and probehavior that is expected. The Behaviora Charge Nurse will ensure that all staff for unit are the appropriate/necessary staff of Staff not assigned to the unit will be not be onto the floor unless performing assigned requiring their presence.	dision on the ag to work. A ported to the addition to this CAP, it tation. The prientation and the ofessional all Health esent on the or the shift. De allowed at duties	6/14/19	
	serious injury, harm, impairment, or death to patients and requires immediate correction action on the part of the hospital. The findings include: Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on	impairment, or death to immediate correction action spital. Health Nursing Notes of the		Quality Monitoring and Accountability CFR(s): 482.13 1.) A Risk Management created to validate compliance of daily redirector of RM will monitor Nursing Superint order to complete the log on a daily based will include verification of the following: In the CEO by the VP of Risk Management, DCF, notifying the Police and documental notification in the medical record. 2.) BH	log was porting. rvisor Report sis. The log otification of notifying tion of DCF created a		
	11/07/2018 at 11:32 F approaches registere that she has been set	PM that at 7:40 PM patient d nurse on duty to complain xually harassed by ntal health technician in her rse and attending		monitoring log to validate Q15 checks. The monitoring will be accomplished by doing unannounced spot-check visual rounding monitoring the camera surveillance in the station real-time. This will be done by Din 3.) VP of Risk will present Lessons Learn as a result of the RCA. In addition, results Monitoring as outlined in this plan will be a monthly basis until completion of the accompletion of the accomp	and by nursing ector of BH. ed at PAC of Quality presented on		

Cattly & McCluba VP, Rish Mgmt/PI

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PRINTED: 06/10/2019 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 100034 B. WING 06/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MOUNT SINAI MEDICAL CENTER MIAMI BEACH, FL 33140 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued from page 5 A 144 Continued From page 5 4.) Education compliance of the Behavioral Health Evidence collected by law enforcement for General Safety Policy will be 100% compliance as analysis. Patient arranges to be transported to exhibited through the sign-in sheet by June 17, 2019. Evidence of compliance will be submitted to the PI rape trauma center at [named] Hospital for department by June 17, 2019. A weekly report will be evaluation as recommended by law enforcement. submitted to the PI department to show evidence of completion for those employees who were not In an interview with (Primary Nurse) Staff-D via scheduled during the roll out of this education. This telephone on 05/29/2019 at 3:25 PM revealed was rolled out by the Director of BH. 5.) Education that nurse was in the hallway when the patient compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning was yelling and mentioned that the Spanish guy electronic report by June 17, 2019. Of those raped me. employees not scheduled during the roll-out of this education, all employees will complete the course Review of Staff-A Disciplinary Action documented before resuming patient care. This is done by the Manager of Training and Development. Evidence of on 11/15/2018 that Reason: failure to follow compliance will be submitted to the PI department by protocol. On Wednesday, November 7, 2018. June 17, 2019. A weekly report will be submitted to employee had 1:1 conversation with patient in the PI department to show evidence of completion for room with no other staff present. Patient later those employees who were not scheduled during the made allegations against staff member, and due roll out of this education 6.) Compliance of the New to the break in protocol (no other staff members Employee education will be documented by the Manager of Training and Development, 100% present, interaction no captured on camera). compliance will be exhibited by signed check lists police had to be called to conduct investigation submitted to the Quality Manager. 7.) Purposeful into patient allegations. Police investigated patient Rounding education will be documented by the allegations, and cleared staff of any wrongdoing. Director of Behavioral Health. 100% compliance will The escalation of this issue could have been be exhibited by sign-in sheet provided to the PI Department. 8.)Director of Risk Management will avoided if employee had followed protocol. audit the reporting process outlined in policy for all Employee was suspended unpaid on Thursday, allegations of sexual misconduct. This audit will 11/08/2018 for one day and received written assure that the appropriate 1:1 observation was counseling signed 11/19/2018. assigned, that the accused employee was suspended/removed, DCF was called and the Police In an interview with Clinical Director Behavioral were notified. Four months of data will be submitted to the Quality Manager to show evidence of 100% Health Unit on 05/29/2019 at 12:41PM revealed compliance. that unless the staff is doing every 15 minute rounding or 1:1, despite gender, at any time in the

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member) with them.

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room they should have a witness (another staff

The employee returned to direct patient care in

the behavioral health department (to include the

inpatient unit and the emergency department

psyche area) pending the results of the DNA



A-144 CFR(s):482.13(c)(2)

or Charge Nurse assigning

The Emergency Department Sexual Assault Protocol

organization-wide policy. The policy was updated to include a section on how to care for a patient who

includes, but is not limited to, the Nursing Supervisor

(Rape) has been revised and adapted as an

states they are a victim of sexual assault which

6-17-19

6/17/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		100034	B. WING		The second second	C 04/2019
	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MIAMI BEACH, FL 33140	1 00/	04/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
A 144	11/30/2018 reveale 11/07/2018, (date o	ge 6 nches for period 11/01/2018 - d patient worked Wednesday, f incident). Employee was on Thursday, 11/08/2018, and	A 144	Continue from page 6 1:1 Patient Safety Tech or Sitter to the Pat Patient Safety Tech or Sitter assigned to the will be the gender of the patients choice. If alleged against an employee, accused embe immediately removed from the area of the allegation and will not be able to return to will not be able to	e Patient it is ployee will he	6/17/19
	returned to regular 11/09/2018.	work schedule on Friday,		cleared pending Human Resources determ The education stressed the importance of i if they witness employees actions that did policy and the consequences associated w following the policy. HR has developed a p	ination. ntervening not follow ith not	6/14/19
1	05/22/2019 that the patient matched the	DNA sample taken from the DNA taken from the mployee was issued a		delineate the process for employees who a investigation by police. Employees under p investigation will be reviewed by the he Se Vice President, CNO, CMO (as appropriate member of HR to make a joint decision on	re under olice rvice Line a) and a	
	05/29/2019 at 3:02F assigned to psyche role, the tech assist documentation and	transported patients from the		appropriateness of the employee returning final report of the actions taken will be reported by the VP of RM. The Sexual Abuse has been added to New Employee Oriental orientation checklist f was revised to validal staff understand the definition of abuse, durand professional behavior that is expected.	to work. A rted to the Education tion. The te that by to report	6/14/19
	in the ED, staff is as unit.	osyche unit and if it is not busy ked to help in the inpatient		Quality Monitoring for A-144 CFR(s):482 1.) BH created a monitoring log to validate checks. This monitoring will be accomplished oing unannounced spot-check visual roun by monitoring the camera surveillance in the	Q15 ed by ding and e nursing	
	"Suspected Patient			station real-time. This will be done by Direct 2.) Education compliance of the Sexual Able education will be 90% compliance as exhib NetLearning electronic report by 6/17/19. Cemployees not scheduled during the roll-out	tor of BH. use ited by the of those t of this	
	protected from abus physical roughness, harassment,. DEFIN Sexual abuse include to a patient verbal of patient's willingness	e of any kind including verbal threats or IITION: SEXUAL ABUSE - es any sexual overture made r physical irrespective of to be involved in it.		education, all employees will complete the before resuming patient care. This is done Manager of Training and Development. Ev compliance will be submitted to the PI depa 6/17/19. A weekly report will be submitted t department to show evidence of completion employees who were not scheduled during out of this education. 3.) Purposeful Round	by the idence of urtment by the PI of those the roll ina	
A 145	PATIENT RIGHTS: I ABUSE/HARASSMI CFR(s): 482.13(c)(3	FREE FROM	A 145	education will be documented by the Direct Behavioral Health. 100% compliance will be by sign-in sheet provided to the PI Departm	or of exhibited	

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Event ID: BILS11

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Cathy J. McClular VP, Risk ngnt; PI 6-17-19

PRINTED: 06/10/2019 FORM APPROVED

ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		100034	B. WING	B. WING		C 06/04/2019	
	ROVIDER OR SUPPLIER	ER .	STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MIAMI BEACH, FL 33140			04/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
A 145	REFIX TAG (EACH DEFICIE REGULATORY OF REGULA	e right to be free from all forms ment. Is not met as evidenced by: eview and staff interviews, les, the facility failed to ensure to be free from all forms of (SP #1) out of 4 sample thospital's failure to ensure om abuse (sexual assault) by ding care and services resulted the lediate jeopardy beginning on going, creating a situation that serious injury, harm, the to patients and requires on action on the part of the		Continue from page 7	illegations at that the the that the the that the that the that the the that the the that the that the the that the the that the the the the that the the that the th	6/17/19	
	Baker Acted on 11/0 recurrent major depideation. She was a Health Unit on 11/0 Review of Behavior (Primary Nurse) Sta 11/07/2018 at 11:32 approaches register that she has been semergency room mroom. Charge nurse	26/2018 at 12:01PM for pressive disorder/suicidal admitted to the Behavioral 6/2018 at 11:00 AM. all Health Nursing Notes of the aff-D, documented on the PM that at 7:40 PM patient ared nurse on duty to complain exually harassed by ental health technician in her and attending psychiatrist anotified. Evidence collected		ensure all allegations of sexual misconduct are reported to the governing board at the PAC. Daily Review of the Nursing Supervisor report by the Director of RM will ensure that all allegations of semisconduct are captured and reported appropriate. The Behavioral Health Charge Nurse will ensure that all staff present on the unit are the appropriate/necessary staff for the shift. Staff not assigned to tunit will be not be allowed onto the floor unless performing assigned duties requiring their present		6/17/19	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED	
		100034	B. WNG			C 06/04/2019	
	ROVIDER OR SUPPLIER	ER	4	TREET ADDRESS, CITY, STATE, ZIP CODE 300 ALTON RD MAMI BEACH, FL 33140			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
A 145	to be transported to [named] Hospital for by law enforcement	nt for analysis. Patient arranges o rape trauma center at or evaluation as recommended nt.	A 145 Continued from Page 8 An education was provided to clinical staff of the process regarding allegations of abuse. definition of sexual assault, their duty to rephow to handle these situations was also couthe education. Nursing Admin held a huddle Nursing Leaders to explain the process of reand what their role is when an allegation is their attention. The Nursing Supervisor will a	A 145	se. The report and covered in Idle with of reporting is brought to	6/17/19	
	Review of Police Report of SP #1 documented on 11/07/2018 at 7:30 PM to 8:00 PM showed that officers responded to the hospital psych ward in reference to a female patient accusing a male employee of the hospital touching her against her will. Officers made contact with complainant who stated that one of the male employees touched her inappropriately in various places about her body. According to patient, the male employee (later to be known as Staff-A) came into her room and began a conversation with her, while he was eating his dinner. Sometime during the		that the proper documentation in the med reflects the date/time/follow up of the photomade to report the incident. Nursing Sup also document the reporting of the incide Nursing Supervisor Report, which will se double-check for RM to follow up with. RI an analysis of the event with staff from B reviewed the surveillance video. A summersons learned will be disseminated to E Health staff, Nursing leadership and PAC "Purposeful Rounding" education was co re-educate staff on the appropriate proto-	dical record one call ervisor will ent on the rve as a M conducted H and mary of Behavioral c. nducted to col when			
	eating his dinner. Some conversation, the ecaressed her breast employee took her hand on his penis. soon after. The pat	Sometime during the employee approached her and st. Patient then stated that hand and forcefully placed her The employee left the room identified the stated that the		conducting rounds or having interactions patients. Longer conversations or 1:1 sur done in the hallway or in an area where the surveillance. Staff who do not complete the education due to scheduling or leave can patient care until they have completed the Quality Monitoring and Accountability	oport will be here is video his not resume e course.	6/17/19	
	15-20 minutes later by kissing and care her inappropriately hand on her vagina a picture of the pattern dressed before lear contact with the error a conversation with physical contact with Review of Staff-A c 11/01/2018 to 11/30	or price came back to the room approximately or minutes later and made another advance using and caressing her breast then touching appropriately by placing his (wet/saliva) on her vagina. The employee allegedly took cure of the patient while she was getting ed before leaving the room. Officers made cut with the employee who admitted to having expression with the patient, but denied any cal contact with the female.		CFR(s): 482.13(c)(3) 1.) BH created a me to validate Q15 checks. This monitoring waccomplished by doing unannounced spowisual rounding and by monitoring the car surveillance in the nursing station real-time be done by Director of BH. 2.) Education of the Sexual Abuse education will be 90° compliance as exhibited by the NetLearni electronic report by 6/17/19. Of those emscheduled during the roll-out of this education the sexual Abuse education will be 90° compliance as exhibited by the NetLearni electronic report by 6/17/19. Of those emscheduled during the roll-out of this education that the sexual Abuse employees will complete the course befor patient care. This is done by the Manager and Development. Evidence of compliance submitted to the PI department by 6/17/19 report will be submitted to the PI department evidence of completion for those employees.	onitoring log will be wit-check mera e. This will compliance % ng eployees not ation, all e resuming of Training ce will be D. A weekly ent to show wies who		
	returned to regular	/2018, (date of incident) and work schedule on Friday, 2/2019 prior to the DNA		evidence of completion for those employe were not scheduled during the roll out of t education.	es who		

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Carly J. Ne Cluber

VP, Rich Mant; PI

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		100034	B. WING		100000	04/2019
	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CO 300 ALTON RD MAMI BEACH, FL 33140		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A 145	Review of 4 Warner 3 Wing) video footage 06/04/2019 revealed exited the room of Sf following times: 1. Staff-A Entered: 7:07:45 PM 2. Staff-A Entered: 7:11:06 PM 3. Staff-A Entered: 7:14:20 PM 4. SP #1 in hallway room at 7:26:04 PM 5. Staff-A in hallway room at 7:31:38 PM 6. SP #1 enters roo follows, Staff-A Exiter 7. SP #1 out of roo to room at 7:32:26 Pl 8. Staff-A walks do follows at 7:33:20 Pl 9. SP #1 enters roo 10. Staff-A Entered: 7:35:23 PM 11. Staff-A Entered: 7:35:58 PM 12. SP #1 out of roo employees and nursi room at 7:41:35 PM 13. SP #1 observed times and pacing the 7:55 PM 14. Police observed In an interview with V Management on 05/2 on 11/05/2018, patier	Southeast Corridor (Female of Staff-A and SP #1 on that Staff-A entered and P #1 on 11/07/2018 at the 7:04:40 PM, Staff-A Exited: 7:08:23 PM, Staff-A Exited: 7:12:47 PM and returns to 9 speaking with SP #1 at 10 PM at 7:31:44 PM and Staff-A 10:13:2:22 PM and returns 10 PM at 7:32:22 PM and returns 11 PM at 7:33:40 PM 7:33:47 PM, Staff-A Exited: 7:35:27 PM, Staff-A Exited: 7:35:27 PM, Staff-A Exited: 7:35:27 PM, Staff-A Exited: 7:37:00 speaks with 10 pm at 7:37:00 speaks with 10 pm at 7:42 PM to 11 PM at 8:49:22	A 145	Continue from page 9 3.) Purposeful Rounding educt documented by the Director of 100% compliance will be exhit provided to the PI Department Management will audit the repoutlined in policy for all allegat misconduct. This audit will assappropriate 1:1 observation was accused employee was suspe was called and the Police were months of data will be submitted Manager to show evidence of	Behavioral Health. ited by sign-in sheet . 4.) Director of Risk orting process ions of sexual ure that the as assigned, that the nded/removed, DCF e notified. Four ed to the Quality	

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Cathy J. Mb. Clubon VP, Rish Mg mt & PI

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED C
	ROVIDER OR SUPPLIER		STRE 4300	ET ADDRESS, CITY, STATE, ZIP COI ALTON RD WI BEACH, FL 33140	06/04/2019 DE
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION DATE
A 145	investigation. Arratransfer patient w Rape Treatment of point, the police in obtained DNA spowas conducted by Resources and the Director, all whome Employee indicate minutes. Last We hospital administration DNA sample take DNA taken from the was arrested. The O5/23/2019, the Nand the Director I Joint Commission Department of Chindings were controlled to the breast and the In an interview win O5/29/2019 at 12 stated the allegate had history of representative and from the until the results of the In an interview winter the policy of the properties of the Interview wind the Interview was in was yelling and many part of the Interview wind the Interview was in was yelling and many patient of the Control of the Interview wind the Interview was in was yelling and many patient of the Control of the Interview wind the Interview was in was yelling and many patient of the Control of the Interview wind the Interview was in was yelling and many patient of the Interview wind the In	d and conducted an angements were made to ith 2-MHT employees to the Center to be evaluated. At some interviewed the employee and ecimen from him. Investigation by Risk Management, Human he Behavioral Health Nursing in spoke with employee. The details of the most of the spoke with employee and the most of the same and the total the police and the vagina. The Director Risk Management on the total and the police ions were unfounded, patient and the DNA testing. The (Primary Nurse) Staff-D via 29/2019 at 3:25 PM revealed the hallway when the patient the hallway when the patient and mplaint. Nurse and patient tient gave the description that technician had entered the tient did not go into detail about	A 145		

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Coutly T. No Cellar UP, Rish Mant's P.I

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VO) AN II TIDI	ONOTOLICTION	OMB NO. 0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	UNSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. BOILDING		
		100034	B. WNG		С
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	06/04/2019
MOUNT	MALMEDICAL CENTE		The second of	ALTON RD	
MOUNTS	INAI MEDICAL CENTE	K		MI BEACH, FL 33140	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	PECTION
PREFIX TAG	(EACH DEFICIEN REGULATORY O	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
A 145	Continued From page	ge 11	A 145	To the second second	/
	Interview with (Char	rge Nurse) Staff-E via		The same and the same	
		019 at 3:35PM revealed that			
	the patient was by t	he room door complaining.			/
	The charge nurse n	otified the Clinical Director			
	Behavioral Health w	hom instructed the charge			
		ice department. The			
	employee was assig	ned to work in the			
	emergency departm	ent psyche intake area and			
	had brought 5 admis	ssions from the emergency			
	department to the b	ehavioral health unit during			
	the 3P-11P shift.				
				1	
	The Rehavioral Hea	Ith policy with the title:			
	"Victims of Abuse A	ssault or Neglect, 16.4.008,"			
	(revised date: 05/20				
		niatry/behavioral health shall			
	strive to identify, trea	at and report all cases of			
	abuse, assault or ne	glect. This included, but is		/	
	not limited to, adult a	and elder abuse and neglect,		/	
	domestic violence, v	rictims of crime and sexual			
	molestation. Staff Ed	ducation: 1. All staff in the			
-	department will rece	ive initial and ongoing training			
	in identifying possibl	e victims of abuse, assault or			
	neglect. 2. Any empl	oyee who knows, or has			
	reasonable cause to	suspect that an aged person			
	or disabled adult is d			/	
	immediately report	ed, or exploited, shall		/	Marie Art. (Control of the Control
	to the Director Direct	uch knowledge or suspicion tor or designee must notify	/		
	the Central Abuse H	otline of the Department of	1		
	Children and Family		/		
	1-800-96-ABUSE (1-		/		All and the same and the
			//		
	"Supported Daties to	th policy with the title:	/		Comment of the latest and the
	(revised data: 05/20	Abuse/Neglect, 16.4.021," I9) states all patients	/		
	admitted to the Dena		/		

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Cathy J. McClellan VI, RM ? PI

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) D/	NO. 0938-039 ATE SURVEY OMPLETED
NAME OF B		100034	B. WING			C 06/04/2019
	ROVIDER OR SUPPLIER INAI MEDICAL CENTER	1	4	TREET ADDRESS, CITY, STATE, ZIP CODE 300 ALTON RD MAMI BEACH, FL 33140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Psychiatry/Behavior protected from abus physical roughness, harassment,. DEFIN Sexual abuse includ to a patient verbal or patient's willingness. The Behavioral Heal Reporting: External a 16.4.015, (revised dincident shall be repined from the Department are informed of the matter patient's medical recall, supportive informed all, supportive informed at the patient's medical recall, supportive information (CFR(s): 482.21). The hospital must demaintain an effective data-driven quality as improvement program. The hospital's govern the program reflects hospital's organization hospital departments those services furnisiarrangement); and for to improved health or and reduction of medical from the posital must matter the position of the position provided matter the positi	al Health Unit shall be e of any kind including verbal threats or IITION: SEXUAL ABUSE - es any sexual overture made physical irrespective of to be involved in it. th policy title:d "Abuse and Internal Events, ate: 06/2016) states that the orted to the Abuse registry at mediately after the Chairman ad/or Nurse Director are er. Documentation in the ord shall include the time of mation, and any follow-up evelop, implement and , ongoing, hospital-wide, ssessment and performance m. hing body must ensure that the complexity of the an and services; involves all and services (including thed under contract or recuses on indicators related autcomes and the prevention	A 263	A-263 CFR(s): 482.21 Risk Management conducted an analevent with staff from BH and reviewer surveillance video. Further action abbeyond as described in this CAP will developed. A summary of lessons lead disseminated to Behavioral Health staleadership and PAC. This event was self-reported to The J Commission. Quality Monitoring and Accountable A-263 CFR:482.21 1. Director of Risk Management will a reporting process outlined in policy for allegations of sexual misconduct. This assure that the appropriate 1:1 observations of the submitted to the Quality Manager to sevidence of 100% compliance. 2. Polica were notified. Four months of continuous continuous discovered by PAC, upload Stat, rolled out to staff and changes we communicated via Policy Memo from Compliance Officer. 3. A Risk Managwas created to validate compliance of reporting. Director of RM will monitor I Supervisor Report in order to complete a daily basis. The log will include verifithe following: notification of the CEO the Risk Management, notifying DCF, noting Police and documentation of DCF notithe medical record. 4.) VP of Risk will Lessons Learned at PAC as a result of 5.) Compliance of the New Employee ewill be documented by the Manager of and Development. 100% compliance of the New Employee exhibited by signed check lists submitt Quality Manager. 6.) Compliance of the Cmanager of Training and Development compliance will be exhibited by signed submitted to the Quality Manager.	d the ove and be arned will be aff, Nursing oint will the rall s audit will wation was was and the data will be how cies listed ded to Policy were the Chief ement log rally Nursing e the log on ication of oy the VP of officiation in present of the RCA. Education for Training will be ted to the lee New ed by the t. 100%	6/13/19

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Carty Tille Callan

VP, RMERI

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
						2	
		100034	B. WING			06/04/2019	
	MOUNT SINAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1300 ALTON RD MIAMI BEACH, FL 33140			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
A 263	This CONDITION Based on record review of policies, and Performance develop, identify of and have an Action improvement; and safety as a result of involving a patient (SP).	tinued From page 13 A 263 CONDITION is not met as evidenced by: sed on record review, staff interviews, and ew of policies, the facility Quality Assessment Performance Improvement Program failed to elop, identify opportunities for improvement have an Action Plan aimed at performance rovement; and provide clear expectations for ty as a result of an incident of sexual assault living a patient (SP #1) of 4 sampled patients A 263 A 283 CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) RM conducted an analysis of the event with staff from provement; and reviewed the surveillance video. A summar of lessons learned will be disseminated to Behavioral Health. 100% compliance will be disseminated t		havioral Health. I by sign-in sheet (1), (c)(3) event with staff from video. A summary nated to Behavioral nd PAC. The Abuse and now includes a g Leaders on how ions. The checklist	6/13/19		
A 283	safety as a result of an incident of sexual assaul involving a patient (SP #1) of 4 sampled patients (SP). (Refer to A-0283 and A-0286). QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that— (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, an quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to		A 283	describes how and when to contact Nursing Director conducts monthly safety rounds through the unit. This to the Behavioral Health Patient Sand then presented at the Organiz Safety Committee. The Behavioral Safety Committee also debriefs ar plans for notable incidents occurris Health units. Risk Management re that are reported in the Behavioral up actions, as necessary, are track reporting system. Policy now state surveillance will be reviewed immediate report. Quality Monitoring and Account CFR(s): 482.21(b)(2)(ii), (c)(1), (c) (iisted above were approved by PA Policy Stat, rolled out to staff and communicated via Policy Memo from Compliance Officer. 2.) A Risk Macreated to validate compliance of CDirector of RM will monitor Nursing in order to complete the log on a dwill include verification of the follow the CEO by the VP of RM, notifyin Police and documentation of DCF medical record. 3.) BH monitoring checks. This monitoring will be accidoing unannounced spot-check vis by monitoring the camera surveilla	y environmental is data is presented afety Committee cation-wide Patient I Health I Health Unit. Follow-ked in the incidents I Health unit. Follow-ked in the incident is that video ediately following the changes were om the Chief anagement log was daily reporting. I g Supervisor Report laily basis. The log wing: notification of g DCF, notifying the notification in the log to validate Q15 complished by sual rounding and	6/17/19	

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Cathy + McClular VP, RM; &I

PRINTED: 06/10/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
100034 R WING	
	C 06/04/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT	
MOUNT SINAI MEDICAL CENTER 4300 ALTON RD MIAMI BEACH, FL 33140	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PI	PLAN OF CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE TAG CROSS-REFE	IVE ACTION SHOULD BE COMPLETION DATE SFICIENCY)
A 283 Continued From page 14 A 283 Continue from page 14 4.) VP of RM will present	t Lessons Learned at PAC as
This STANDARD is not met as evidenced by: a result of the RCA. In add	ddition, results of Quality
Based on record review staff intonious and Monitoring will be present	ited on a monthly basis until
rovious of policies the facility fails of a file	plan. 5.) Education compliance
of the bit odicial dalety	through the sign-in sheet by
	npliance will be submitted to
performance improvement as a result of an a the PI department by Jun	ne 17, 2019. A weekly report
sexual assault incident involving 1 (SD #1) of 4 will be submitted to the P	PI department to show
sampled patients (SP).	or those employees who were roll out of this education. This
was rolled out by the Dire	ector of BH. 6.) Education
The findings include:	Abuse education will be 90%
	by the NetLearning electronic
	se employees not scheduled education, all employees will
complete the course before is done by the Manager of	ore resuming patient care. This of Training and Development.
Clinical Record review of sample patient (SP) #1, Evidence of compliance v	will be submitted to the PI
revealed she arrived in the ER (Emergency department by 6/17/19. A	weekly report will be
	tment to show evidence of
schoduled during the sell	out of this education 7)
Compliance of the New E	mployee education will be
ideation. She was admitted to the Behavioral documented by the Mana	ager of Training and
Health Unit on 11/06/2018 at 11:00 AM. Development, 100% compaigned check lists submitted.	pliance will be exhibited by ted to the Quality Manager.
Review of Behavioral Health Nursing Notes of the 8.) Purposeful Routing 6	education will be documented
(Brimany Numa) Staff D. day and the day of the Director of Behavior	oral Health, 100% compliance
will be exhibited by sign-ir	n sheet provided to the PI
approaches registered nurse on duty to complain	
that she has been sexually harassed by	
emergency room mental health technician in her	
room 474. Charge nurse and attending	
psychiatrist made aware. Police notified.	
Evidence collected by law enforcement for	
analysis. Patient arranges to be transported to	
rape trauma center at [named] Hospital for	
evaluation as recommended by law enforcement.	
In an interview with Vice President Risk	
Management on 05/29/2019 at 11:07AM revealed	
on 11/05/2018, patient complained of being	

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Cottly & Mc Cellan VP, RM; PI

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		& MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100034		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING		C 06/04/2019	
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2013
MOUNTS	INAI MEDICAL CENTE	R		00 ALTON RD AMI BEACH, FL 33140	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
A 283	Continued From pa	ge 15	A 283		
		by a Mental Health Technician	7,200		
	(MHT) and identifie	d employee by name. The			
	police were called a			The second section and the second section is a second section of the second section of the second section sect	-/-
	investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee				
				/	
				/	
				A STATE OF THE STA	
				And the second second second	
					the same of the sa
	minutes. Last Wedr	nesday, 05/22/2019, the			
	hospital administrat	tion was informed that the			
		from the patient matched the		/	
		e employee and the employee		/	
		ollowing day, Thursday,			
		e President Risk Management			
		sk Management notified the out did not notify the			a white the same of
		dren's and Families. The DNA			
		stent with the police report, on			
	the breast and the i	n the vagina. The actual			
	results were not pro				
		riada to the identy.			
	Interview with Clinic	cal Director Behavioral Health			
		02PM revealed the employee			
	Staff A attended a 1	-day training on 05/22/2019		/	
	and went to police s	station. This was the last day	/	The particular of the state of	Althorn Company
- 4	of work for the empl	loyee. The Clinical Director	/		
		ad a staff meeting on			
	11/15/2018, to discuss mandatory education on abuse and neglect and remind staff about not entering patient rooms alone. Review of		/		
			/	The state of the second	
			/		
	Behavioral Health G	General Staff Meeting Agenda			
	documented on 11/		- /		
	Findings/Conclusion	ns: Only enter patient room	/		
		ounds or quickly completing	/		
	duties/tasks. Do not	have 1:1 conversations alone			

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Country McClubon rp, Rm; PI

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
NAME OF P	DOMINED ON SURBLUES	100034	B. WING		06/04/2019
	ROVIDER OR SUPPLIER	ER	4300	EET ADDRESS, CITY, STATE, ZIP CODE ALTON RD MI BEACH, FL 33140	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
A 283	Continued From pa	age 16	A 283		/
	best way to protect possible physical v	ardless of gender. This is the t yourself from allegations and violence. (Action: Longer conversations			
	or 1:1 support sho	uld be given in hallway or where on camera). Any longer			
	activity, get second Non-behavioral he	d staff. No students or alth staff to be left alone with			
	patients. Accompany them to rooms. Review of				
		chiatry/Behavioral Health			
	Sign-in sheet revea	aled approximately 51			
	signatures out of a	pproximately 86 staff members			
		policy was written or corrective plemented after the incident.			
	The Policy titled: " Occurrences, 1.28.	Sentinel Events and Significant 026," (revised date: 06/2018)			
	states that sexual a	abuse/assault including "rape"			
		onsensual sexual contact			
		and another patient, staff		/	manufacture of the second
	member, or other p	erpetrator while being treated			
	or on the premises	of the hospital, including oral,			
	vaginal or anal pen	etration or fondling of the			
		s) by another individual's			
		object. One or more of the			
	following must be p	resent to determine that it is a			
	sentinel event: Any	staff witnessed sexual contact			The state of the s
	as described above	e, sufficient clinical evidence		/	
	unconcented sevue	spital to support allegations of all contact or admission by the	1		
		cual contact, as described	/		
		the premises. A thorough and	/		
		e Analysis will be conducted			
		ent as defined in this policy.	/		
	The hospital dissen	ninates lessons learned from			
	root cause analyse	s, system or process failures			
	to all staff who prov situation.	ride services for the specific	/		

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Event ID: BILS11 Facility ID: HL100034

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Carty McCellan VP, RM SPI

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/10/2019 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 100034 B. WING 06/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MOUNT SINAI MEDICAL CENTER MIAMI BEACH, FL 33140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY A-286 CFR(s): 482.21(a), (c)(2), (e)(3) A 286 Continued From page 17 A 286 A 286 PATIENT SAFETY A 286 Risk Management conducted an analysis of the CFR(s): 482.21(a), (c)(2), (e)(3) event with staff from BH and reviewed the surveillance video. Further action above and (a) Standard: Program Scope beyond as described in this CAP will be developed. 6/13/19 (1) The program must include, but not be limited A summary of lessons learned will be disseminated to, an ongoing program that shows measurable to Behavioral Health staff, Nursing leadership and PAC. Quality Monitoring as a result of this analysis improvement in indicators for which there is will be rolled out and shared as described above. evidence that it will ... identify and reduce medical errors. The Abuse and Neglect Policy was updated and (2) The hospital must measure, analyze, and now includes a checklist attached to guide Nursing 6/17/19 track ...adverse patient events ... Leaders on how to handle and report these allegations. The checklist describes how and when to contact Risk Management. (c) Program Activities (2) Performance improvement activities must The Behavioral Health Nursing Director conducts track medical errors and adverse patient events, monthly environmental safety rounds through the analyze their causes, and implement preventive unit. This data is presented to the Behavioral Health Patient Safety Committee and then presented at the actions and mechanisms that include feedback Organization-wide Patient Safety Committee. The and learning throughout the hospital. 6/17/19 Behavioral Health Patient Safety Committee also debriefs and develops action plans for notable (e) Executive Responsibilities, The hospital's incidents occurring in the Behavioral Health units. governing body (or organized group or individual who assumes full legal authority and responsibility An education titled "Purposeful Rounding" was for operations of the hospital), medical staff, and conducted to re-educate staff on the appropriate administrative officials are responsible and protocol when conducting rounds or having interactions with patients. Longer conversations or accountable for ensuring the following: ... 6/17/19 1:1 support will be done in the hallway or in an area (3) That clear expectations for safety are where there is video surveillance. Staff who do not established. complete this education due to scheduling or leave This STANDARD is not met as evidenced by: cannot resume patient care until they have Based on record review, staff interviews, and completed the course. review of policies, the facility governing body Quality Monitoring and Accountability for A-286 failed to assume responsibility in setting clear CFR(s): 482.21(a), (c)(2), (e)(3) 1.) Policies listed expectations for safety as a result of an incident above were approved by PAC, uploaded to Policy of sexual assault involving a patient (SP #1) of 4 Stat, rolled out to staff and changes were

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sampled patients (SP).

The findings include:

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Carty J. McChilas

Clinical Record review of sample patient (SP) #1,

VP, Risk inquitiPI

daily basis.

communicated via Policy Memo from the Chief Compliance Officer. 2.) A Risk Management log was created to validate compliance of daily reporting. Director of RM will monitor Nursing

Supervisor Report in order to complete the log on a

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		X WEDICAID SERVICES			OMB NO	D. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100034		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		04/2019
MOUNT S	INAI MEDICAL CENTER	•		4300 ALTON RD MIAMI BEACH, FL 33140		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 286	Continued From page 18 revealed she arrived in the ER (Emergency Room) on 11/05/2019 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal		A 286	Continue from page 18		
			,,200			
				The log will include verification of the	rollowing:	
				notification of the CEO by the VP of RM, notifying DCF, notifying the Police and documentation of D notification in the medical record. 3.) BH monitori		
	ideation. She was a	dmitted to the Behavioral		log to validate Q15 checks. This monitoring will		
	Health Unit on 11/06/2018 at 11:00 AM. Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain			accomplished by doing unannounced visual rounding and by monitoring the surveillance in the nursing station real	camera	
				be done by Director of BH. 4.) VP of F	RM will present	
				Lessons Learned at PAC as a result of the RCA. In addition, results of Quality Monitoring will be presented on a monthly basis until completion of the		
	that she has been se	exually harassed by		action plan. 5.) Education compliance of the BH General Safety Policy will be 100% compliance		
		ental health technician in her		exhibited through the sign-in sheet by	6/17/19	
	room 474. Charge n	urse and attending		Evidence of compliance will be submit	tted to the PI	
	psychiatrist made av	vare. Police notified.		department by June 17, 2019. A week	dy report will be	
		by law enforcement for		submitted to the PI department to sho	w evidence of	
	analysis. Patient arranges to be transported to			completion for those employees who is scheduled during the roll out of this ed	were not	
	rape trauma center a	ape trauma center at [named] Hospital for		was rolled out by the Director of BH. 6	i.) Education	
	evaluation as recommended by law enforcement. In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed			compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic report by 6/17/19. Of those employees scheduled during the roll-out of this education, all		
			-			
	on 11/05/2018, patie	nt complained of being		employees will complete the course be patient care. This is done by the Mana	erore resuming	
100	sexually assaulted by	y a Mental Health Technician		and Development. Evidence of compl	liance will he	
	(MHT) and identified employee by name. The police were called and conducted an investigation. Arrangements were made to			submitted to the PI department by 6/1	7/19. A weekly	
				report will be submitted to the PI depa	rtment to show	
				evidence of completion for those empl	oyees who	
	transfer patient with	2-MHT employees to the		were not scheduled during the roll out education. 7.) Compliance of the New	or this Employee	
	Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and			education will be documented by the M	Manager of	
1				Training and Development. 100% com	pliance will be	
	obtained DNA specin	nen from him. Investigation		exhibited by signed check lists submitt	ted to the	
	was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the			Quality Manager. 8.) Purposeful Roundwill be documented by the Director of I	ding education	
				Health. 100% compliance will be exhib	ited by sign_in	
				sheet provided to the PI Department.	aca by sign-in	
	hospital administration	on was informed that the	-			
	DNA sample taken fr	om the patient matched the				
	DNA taken from the	employee and the employee	-			

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Carty J. No. Cellan

VP, Rich mant ; BI

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	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C			
NAME OF PROVIDER OR SUPPLIER MOUNT SINAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MIAMI BEACH, FL 33140			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
A 286	o5/23/2019, the Vi and the Director R Joint Commission Department of Chi findings were const the breast and the results were not provided in the Interview with Clinion o5/29/2019 at 3 Staff A attended a and went to police of work for the empedational Health 11/15/2018, to disc abuse and neglect entering patient roce Behavioral Health documented on 11. Findings/Conclusic alone when doing a duties/tasks. Do not in room, this is registed best way to protect possible physical versible physical ver	following day, Thursday, ce President Risk Management isk Management notified the but did not notify the Idren's and Families. The DNA istent with the police report, on in the vagina. The actual ovided to the facility. cal Director Behavioral Health 202PM revealed the employee 1-day training on 05/22/2019 station. This was the last day ployee. The Clinical Director had a staff meeting on the same alone. Review of General Staff Meeting Agenda (15/2018 revealed ins: Only enter patient room tounds or quickly completing of thave 1:1 conversations alone ardless of gender. This is the syourself from allegations and	A 286			

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Cotthy J. McClubar VP, Rush Mgmt; PI

PRINTED: 06/10/2019 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 100034 B. WING 06/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4300 ALTON RD MOUNT SINAI MEDICAL CENTER MIAMI BEACH, FL 33140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 286 Continued From page 20 A 286 Occurrences, 1.28.026," (revised date: 06/2018) states that sexual abuse/assault including "rape" is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patients sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event: Any staff witnessed sexual contact as described above, sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact or admission by the perpetrator that sexual contact, as described above, occurred on the premises. A thorough and credible Root Cause Analysis will be conducted for any Sentinel Event as defined in this policy. The hospital disseminates lessons learned from root cause analyses, system or process failures to all staff who provide services for the specific situation.

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Cathy J. We Clillan

VP, RM; PI